FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045690

Facility Name: Fireside House of Centralia

Address: 1030 Martin Luther King (Number) Centralia (City) 62801 (Zip Code)

County: Marion

Telephone Number: 618-532-1833 **Fax #** 618-532-1308

HFS ID Number: 6001614

Date of Initial License for Current Owners: 1-29-2002

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Kathy Goggin Director **Telephone Number:** 770-619-0866

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 4/30/06 (Date)
(Type or Print Name) Douglas Mittleider
(Title) President of Management Company

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Matthew Larson, Reimbursement Analyst
(Firm Name & Address) AltaCare Corporation, 925 Northpoint Pkwy Suite 440 Alpharetta, GA 30005
(Telephone) (770) 870-2881 Fax # (770) 619-0262

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,615	1
2		Skilled Pediatric (SNF/PED)			2
3	47	Intermediate (ICF)	47	17,155	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,396	629	5,377	16,402	8
9	SNF/PED					9
10	ICF	11,964	3,964	30	15,958	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,360	4,593	5,407	32,360	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.47%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-29-2002

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-29-2002 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided ____

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12-31 Fiscal Year: 12-31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	135,122	13,042	7,553	155,717		155,717		155,717			1
2	Food Purchase		150,435		150,435		150,435		150,435			2
3	Housekeeping	90,545	17,008		107,553		107,553		107,553			3
4	Laundry	61,655	11,008		72,663		72,663		72,663			4
5	Heat and Other Utilities			112,590	112,590		112,590		112,590			5
6	Maintenance	23,416	8,970	19,230	51,616		51,616		51,616			6
7	Other (specify):*			5,887	5,887		5,887		5,887			7
8	**TOTAL General Services**	310,738	200,463	145,260	656,461		656,461		656,461			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,317,899	84,854	6,080	1,408,833		1,408,833		1,408,833			10
10a	Therapy	167,425	2,455	11,894	181,774		181,774		181,774			10a
11	Activities	29,110	1,607	2,232	32,949		32,949		32,949			11
12	Social Services	20,508		2,081	22,589		22,589		22,589			12
13	CNA Training											13
14	Program Transportation			475	475		475	(475)				14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,534,942	88,916	34,762	1,658,620		1,658,620	(475)	1,658,145			16
	C. General Administration											
17	Administrative	53,275			53,275	20,318	73,593		73,593			17
18	Directors Fees											18
19	Professional Services			283,934	283,934		283,934	(279,570)	4,364			19
20	Dues, Fees, Subscriptions & Promotions			9,284	9,284	1,884	11,168	198	11,366			20
21	Clerical & General Office Expenses	202,771	13,114	62,805	278,690	(22,202)	256,488	65,709	322,197			21
22	Employee Benefits & Payroll Taxes			370,692	370,692		370,692	106,516	477,208			22
23	Inservice Training & Education			2,026	2,026		2,026	582	2,608			23
24	Travel and Seminar			2,743	2,743		2,743	788	3,531			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,812	88,812		88,812	21,786	110,598			26
27	Other (specify):*			94,046	94,046		94,046	(93,846)	200			27
28	**TOTAL General Administration**	256,046	13,114	914,342	1,183,502		1,183,502	(177,837)	1,005,665			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,101,726	302,493	1,094,364	3,498,583		3,498,583	(178,312)	3,320,271			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fireside House of Centralia #0045690 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			103,240	103,240		103,240	2,354	105,594			30
31	Amortization of Pre-Op. & Org.			15,576	15,576		15,576	355	15,931			31
32	Interest			321,341	321,341		321,341	3,915	325,256			32
33	Real Estate Taxes			51,440	51,440		51,440	1,173	52,613			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,840	8,840		8,840	202	9,042			35
36	Other (specify):*											36
37	**TOTAL Ownership**			500,437	500,437		500,437	7,999	508,436			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,173	2,173		2,173	(2,173)				38
39	Ancillary Service Centers		190,619	2,836	193,455		193,455	447	193,902			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*			13,280	13,280		13,280		13,280			43
44	**TOTAL Special Cost Centers**		190,619	71,944	262,563		262,563	(1,726)	260,837			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,101,726	493,112	1,666,745	4,261,583		4,261,583	(172,039)	4,089,544			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(612)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,173)	38		16
17	Non-Care Related Fees	(475)	14		17
18	Fines and Penalties	(3,524)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(80,636)	27		24
25	Fund Raising, Advertising and Promotional	(2,470)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,166)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,056)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(55,983)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (55,983)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (172,039)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Fireside House of Centralia

ID# 0045690

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Copying Revenue	$ (233)	21	1
2	Over Draft Fees	(3,537)	21	2
3	Resident Expense	(1,128)	27	3
4	Prior Year Expense	(12,082)	27	4
5	Prior Year expense Ancillary	692	39	5
6	Late Charges	(7,077)	21	6
7	Interest on Debt payment	(2,801)	32	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(26,166)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fireside House of Centralia # 0045690 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(475)	0	0	0	0	0	0	0	0	0	0	(475)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(475)	0	0	0	0	0	0	0	0	0	0	(475)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(279,570)	0	0	0	0	0	0	0	0	0	(279,570)	19
20	Fees, Subscriptions & Promotions	(2,470)	2,668	0	0	0	0	0	0	0	0	0	198	20
21	Clerical & General Office Expenses	(14,371)	80,080	0	0	0	0	0	0	0	0	0	65,709	21
22	Employee Benefits & Payroll Taxes	0	106,516	0	0	0	0	0	0	0	0	0	106,516	22
23	Inservice Training & Education	0	582	0	0	0	0	0	0	0	0	0	582	23
24	Travel and Seminar	0	788	0	0	0	0	0	0	0	0	0	788	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	21,786	0	0	0	0	0	0	0	0	0	21,786	26
27	Other (specify):*	(93,846)	0	0	0	0	0	0	0	0	0	0	(93,846)	27
28	**TOTAL General Administration**	(110,687)	(67,150)	0	0	0	0	0	0	0	0	0	(177,837)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(111,162)	(67,150)	0	0	0	0	0	0	0	0	0	(178,312)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Fireside House of Centralia** **#** **0045690** **Report Period Beginning:** **1/1/2005** **Ending:** **12/31/2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	2,354	0	0	0	0	0	0	0	0	0	2,354	30
31	Amortization of Pre-Op. & Org.	0	355	0	0	0	0	0	0	0	0	0	355	31
32	Interest	(3,413)	7,328	0	0	0	0	0	0	0	0	0	3,915	32
33	Real Estate Taxes	0	0	0	1,173	0	0	0	0	0	0	0	1,173	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	202	0	0	0	0	0	0	0	202	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,413)	10,037	0	1,375	0	0	0	0	0	0	0	7,999	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(2,173)	0	0	0	0	0	0	0	0	0	0	(2,173)	38
39	Ancillary Service Centers	692	(245)	0	0	0	0	0	0	0	0	0	447	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,481)	(245)	0	0	0	0	0	0	0	0	0	(1,726)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(116,056)	(57,358)	0	1,375	0	0	0	0	0	0	0	(172,039)	45

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LTC of Illinois - Fireside Subsidiary of	100%	LTC of Friendship	Centralia	AltaCare-HP/Manager	Alpharetta, GA	Mgt Co
Sentry Health Care Acquirors				HP/Ancillaries	Alpharetta, GA	Medical/Diet Supplie

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	39	Medical Supplies	$ 7,628	HP/Ancillaries	100.00%	$ 7,383	$ (245)	1
2	V	19	Accounting Fees	30,000	AltaCare-HP/Management Services	100.00%		(30,000)	2
3	V	19	Management Services	250,544	AltaCare-HP/Management Services	100.00%		(250,544)	3
4	V	19	Non related Prof Services		AltaCare-HP/Management Services	100.00%	974	974	4
5	V	20	Dues		AltaCare-HP/Management Services	100.00%	2,668	2,668	5
6	V	21	Clerical		AltaCare-HP/Management Services	100.00%	80,080	80,080	6
7	V	22	Benefits & Payroll Taxes		AltaCare-HP/Management Services	100.00%	106,516	106,516	7
8	V	23	Training		AltaCare-HP/Management Services	100.00%	582	582	8
9	V	24	Travel & Seminars		AltaCare-HP/Management Services	100.00%	788	788	9
10	V	26	Liability Insurance		AltaCare-HP/Management Services	100.00%	21,786	21,786	10
11	V	30	Depreciation		AltaCare-HP/Management Services	100.00%	2,354	2,354	11
12	V	31	Amortization		AltaCare-HP/Management Services	100.00%	355	355	12
13	V	32	non Related Party interest		AltaCare-HP/Management Services	100.00%	7,328	7,328	13
14	Total			$ 288,172			$ 230,814	$ * (57,358)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real Estate Taxes	$	AltaCare-HP/Management Services	100.00%	$ 1,173	$ 1,173	15
16	V	35	Equipment & Vehicle Rent		AltaCare-HP/Management Services	100.00%	202	202	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,375	$ * 1,375	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AltaCare-HP/Management Services
Street Address: 925 North Point Pkwy, Suite 440
City / State / Zip Code: Alpharetta, GA 30005
Phone Number: (770-619-0866
Fax Number: (770-619-0262

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management Fees	Total Expense	170,964,458	66	$ 8,560,813	$ 5,709,106	4,261,584	$ 213,393	1
2	32	Capital	Total Expense	170,964,458	66	457,828	0	4,261,584	11,412	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 9,018,641	$ 5,709,106		$ 224,805	25

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	GMAC		x	Purchase of Facility	$28,284.00	1/25/02	$ 3,739,000	$ 3,524,535	2/1/2007	7.7500	$ 283,050	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DVI		X	AR Financing		1/29/02	Variable	480,888	Variable	Variable	33,640	6
7	Insurance		X	Liability & WC Insurance		11/1/04	Variable			Variable	1,849	7
8												8
9	TOTAL Facility Related				$28,284.00		$ 3,739,000	$ 4,005,423			$ 318,539	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,739,000	$ 4,005,423			$ 318,539	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Fireside House of Centralia **#** 0045690 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,440	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 51,440	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002		10
2003		11
2004	51,440	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fireside House of Centralia COUNTY Marion

FACILITY IDPH LICENSE NUMBER 0045690

CONTACT PERSON REGARDING THIS REPORT Kathy Goggin

TELEPHONE 770-619-0866 FAX #: 770-619-0262

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	00001030	Land & building	$ 51,440.00	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,440.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,800 B. General Construction Type: Exterior Brick Frame Concrete/Stucco Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

LTC of Illinois - Friendship Manor of Centralia LTC Facility 23,100 sq ft 94 Beds
100 Martin Luther King Drive
Centralia, IL 62801

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 90,261
2. Number of Years Over Which it is Being Amortized: $53,715 for 5 years/$25k for 30y
3. Current Period Amortization:
4. Dates Incurred: Began February 2002

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		162,206	2002	$ 32,463	1
2					2
3	TOTALS	162,206		$ 32,463	3

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2002	1963	$ 2,921,367	$ 73,067	40	$ 73,067	$ 0	$ 284,489	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot Resurfacing-Howell Asphalt			2002	16,687	1,112	15	1,112		3,801	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,938,054	$ 74,179		$ 74,179	$ 0	$ 288,290	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 203,644	$ 27,956	$ 27,956	$	7&10	$ 107,554	71
72	Current Year Purchases	14,674	897	897		10	897	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 218,318	$ 28,853	$ 28,853	$		$ 108,451	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,188,835	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,032	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 103,032	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 396,741	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 8,840 Description: Copier Lease $5363 &Other small equipment $3477
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		3549	hrs	$ 94,248		$ (11,339)	$ 419	3,549	$ 83,328	1
2	Licensed Speech and Language Development Therapist		50	hrs	2,258		21,688	47	50	23,993	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist		2703	hrs	70,918		1,545	1,988	2,703	74,451	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts			164,050			164,050	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): Lab & Radiology						10,246			10,246	13
14	TOTAL				$ 167,424		$ 186,190	$ 2,454	6,302	$ 356,068	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fireside House of Centralia **#** 0045690 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (66,803)	$	1
2	Cash-Patient Deposits	12,734		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	339,893		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,241		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,061,338		8
9	Other(specify):	757,398		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,131,801	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,463		13
14	Buildings, at Historical Cost	2,921,367		14
15	Leasehold Improvements, at Historical Cost	16,687		15
16	Equipment, at Historical Cost	231,620		16
17	Accumulated Depreciation (book methods)	(404,315)		17
18	Deferred Charges	33,374		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	133,550		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,964,746	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,096,547	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 460,908	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,734		28
29	Short-Term Notes Payable	556,886		29
30	Accrued Salaries Payable	138,167		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,564		31
32	Accrued Real Estate Taxes(Sch.IX-B)	51,440		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,252,699	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,455,974		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,455,974	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,708,673	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 387,873	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,096,546	$	48

***(See instructions.)**

Facility Name & ID Number Fireside House of Centralia # 0045690 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 395,963	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 395,963	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(8,090)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (8,090)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 387,873	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,882,865	1
2	Discounts and Allowances for all Levels	180,215	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,063,080	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,883	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 110,883	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	755	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	172	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 927	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	612	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 612	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		77,991	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,991	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,253,493	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	656,460	31
32	Health Care	1,658,621	32
33	General Administration	1,183,502	33
	B. Capital Expense		
34	Ownership	500,437	34
	C. Ancillary Expense		
35	Special Cost Centers	208,908	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,261,583	40
41	**Income before Income Taxes (line 30 minus line 40)****	(8,090)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (8,090)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,873	2,120	$ 70,780	$ 33.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,401	15,651	312,617	19.97	3
4	Licensed Practical Nurses	19,605	22,897	380,007	16.60	4
5	CNAs & Orderlies	56,144	65,571	540,190	8.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,257	3,565	29,110	8.17	10
11	Social Service Workers	1,754	2,069	20,508	9.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,526	17,600	135,122	7.68	15
16	Dishwashers					16
17	Maintenance Workers	2,013	2,229	23,417	10.51	17
18	Housekeepers	11,081	12,376	90,545	7.32	18
19	Laundry	8,193	8,975	61,655	6.87	19
20	Administrator	2,080	2,080	73,593	35.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,251	7,293	182,451	25.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,263	1,384	14,301	10.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,441	163,810	$ 1,934,296 *	$ 11.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	200	$ 7,553	1.3	35
36	Medical Director		12,000	9.3	36
37	Medical Records Consultant	40	2,157	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,232	11.3	44
45	Social Service Consultant	40	2,081	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 26,023		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Eifert			$ 73,593
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,593

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ziemer Stayman Weitzel	Legal	$ 365
AltaCare Corp	Accounting	30,000
Payday	Payroll	2,641
Longterm Care Services Inc	Auditing	228
AltaCare Corp	Management Fees	250,544
Alloc Ct Corp	Agent	156
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 283,934

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,216
Unemployment Compensation Insurance	
FICA Taxes	220,518
Employee Health Insurance	11,081
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Appreciation	2,750
Life Insurance	6,069
Dental Insurance	58
Related Party Adjustment	106,516
TOTAL (agree to Schedule V, line 22, col.8)	$ 477,208

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 104
Advertising: Employee Recruitment	830
Health Care Worker Background Check	1,884
(Indicate # of checks performed 68)	
Avertising Promo	2,092
Dues	6,258
Related Purchases	2,668
Less: Public Relations Expense	(378)
Non-allowable advertising	(2,092)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,366

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,843
In-State Travel	810
HO Adjustment	788
Seminar Expense	90
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,531

**See instructions.

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fireside House of Centralia # 0045690 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ILHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ _____
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.